**CONSUMER REFERRAL**

*\*Please note if crisis assistance is required, please contact Emergency Services on 000 or your local Mental Health Service Acute Care Team.*

| **Referral Date:** |  | | **Client or Parent/Guardian/Carer consent for this referral** *(if aged 12-18):*☐ Yes ☐ No | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Type** | ☐ Workcover ☐ Employee Assistance Program (EAP)  ☐ Other | | | | | | | | | |
| **Service Location:** | ☐ Rockhampton ☐ Thursday Island ☐ Nambour  ☐ Other *(Please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | | | | | | | | | |
| **REFERRER DETAILS** | | | | | | | | | | |
| **Name of referrer:** |  | | | **Organisation:** | | |  | | | |
| **Referrer position/ profession:** |  | | | **Provider number:**  *(if applicable)* | | |  | | | |
| **Phone:** |  | | | **Email:** | | |  | | | |
| **Address:** |  | | | | | | | ☐ **Experiencing homelessness** | | |
| **CONSUMER DETAILS:** | | | | | | | | | | |
| **Name:** |  | | | **Preferred Name** | | |  | | | |
| **D.O.B.** |  | | | **Gender:** | | |  | | | |
| ☐ **Aboriginal** ☐ **Torres Strait Islander** ☐ **Both**  ☐ **Neither** | | | | | | ☐ **Culturally & Linguistically Diverse Background** | | | | |
| **Address:** |  | | | | | | | | | |
| **Phone numbers:** |  | | | | | | | | | |
| **Email:** |  | | | | | | | | | |
| **Parent/Carer/**  **Guardian Name:**  *(if aged 12-18)* |  | | | | **Relationship to youth:** | | |  | | |
| **Contact details:** |  | | | | | | | | | |
| **ADDITIONAL INFORMATION:** | | | | | | | | | | |
| **Reason for Referral:** | |  | | | | | | | | |
| **Consumers goals and hopes:** | |  | | | | | | | | |
| **Key Issues identified by consumer and worker:** | | * Psychological support * Physical health * Housing/Accommodation * Substance use * Financial * Employment | | | * Relationships * Domestic & Family Violence * Social * Education * Isolation | | | | * Other: | |
| **Mental Health Diagnosis:**  *(if applicable)* | |  | | | | | | | | |
| **Mental Health Care Plan completed:** | | ☐ Yes *(please attach)* ☐ No | | | | | | | | |
| **Medication details:**  *(if applicable)* | |  | | | | | | | | |
| **Outcomes/scores of any relevant psychosocial assessments:**  (*e.g. K5, K10, SDQ*) | |  | | | | | | | | |
| **Risk of harm to self:** | | Is the person currently self-harming ☐ Yes ☐ No  Is the person at increased risk of suicide ☐ Yes ☐No  *\*If assessed at high risk of suicide please contact Emergency Services on 000 or Mental Health Service Acute Care Team* | | | | | | | | |
| **Are there any risk factors we should be aware of?** | | ☐ No ☐ Yes *(please specify below or attach existing risk assessment)* | | | | | | | | |
| **Other services consumer is accessing:** | |  | | | | | | | | |
| **Other relevant information:** | |  | | | | | | | | |
| **CONSUMER PREFERENCES** | | | | | | | | | | |
| **Preferred Gender of Worker:** | ☐ Female  ☐ Male | | | | | | | | | |
| **Preferred contact method:** | ☐ Mobile ☐ Home phone \*Ok to leave voicemail/send SMS: ☐ Yes ☐ No  ☐ Email ☐ via Referrer ☐ Home visit | | | | | | | | | |
| **Other preferences:** |  | | | | | | | | | |

**This form can be delivered to Wakai Waian Healing by:**

**For the Rockhampton and Nambour offices or Other locations please send to:**

**Fax:** (07) 4829 4011

**Email:** referralscq@wakai-waian.com.au

**Postal:** PO Box 4080, Rockhampton,QLD,4700

**In person:** 104 Fitzroy Street, Rockhampton QLD, 4700

**For the Thursday Island Office please send to:**

**Fax:** (07) 4829 4011

**Email:** referralsti@wakai-waian.com.au

**Postal:** P.O. Box 767, Thursday Island, QLD, 4875

**In person:** Unit 3, 40 Douglas St, Thursday Island QLD, 4875

**Further Information:**

Freecall: 1800 732 850 or Email: [enquiries@wakai-waian.com.au](mailto:enquiries@wakai-waian.com.au)